PRINTED: 06/23/2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NV\$4009AGC

NAME OF PROVIDER OR SUPPLIER

HOME OF FAITH AND HAPPINESS

SIMMARY STATEMENT OF DEFICIENCIES

NV\$4009AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

6418 SPRING MEADOW DRIVE
LAS VEGAS, NV 89103

PROVIDER'S PLAN OF CORRECTION

O(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) DATE SURVEY COMPLETED

(X4) DATE SURVEY COMPLETED

(X4) DATE SURVEY COMPLETED

(X5) DATE SURVEY COMPLETED

(X6) DATE SURVEY COMPLETED

(X6) DATE SURVEY COMPLETED

(X6) DATE SURVEY COMPLETED

(X7) DATE

HOME OF	FAITH AND HAPPINESS	6418 SPRING MEADOW DRIVE LAS VEGAS, NV 89103				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 000	Initial Comments		Y 000			
	This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on June 16, 2006. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.					
	The facility is licensed for six (6) Residential Facility for Group beds for elderly and disab persons and/or persons with mental illness. census at the time of the survey was three (residents. One (1) resident file was reviewed one (1) employee file was reviewed.	led The 3)				
	As a result of the survey, the facility will receive a grade of "D".					
	There were no complaints investigated.					
	The following deficiencies were identified.					
Y 050 SS=C	449.194(1) Administrator's Responsibilities-Oversight		Y 050			
	NAC 449.194 The administrator of a residential facility shat. Provide oversight and direction for the members of the staff of the facility as necess to ensure that residents receive needed sen and protective supervision and that the facilitin compliance with the requirements of NAC	sary vices ity is				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING \_ NVS4009AGC 06/16/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OME OF	FAITH AND HAPPINESS	6418 SPRING MEADOW DRIVE LAS VEGAS, NV 89103				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 050	Continued From page 1		Y 050			
	449.156 to 449.2766, inclusive, and chapter of NRS.	449				
	This Regulation is not met as evidenced by: Based on record review, observation and interview on 6/16/09, the administrator failed keep the records of the facility complete and accurate.  Severity: 1 Scope: 3	I to				
Y 070 SS=F	449.196(1)(f) Qualifications of Caregiver-8 h training	ours	Y 070			
	NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility.					
	This Regulation is not met as evidenced by: Based on record review on 6/16/09, the facility failed to ensure that 3 of 3 caregivers received eight hours of annual training (Employee #1, #2 and #3).					
	This was a repeat deficiency of the 8/29/09 State Licensure survey.					
	Severity: 2 Scope: 3					

PRINTED: 06/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS4009AGC 06/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6418 SPRING MEADOW DRIVE **HOME OF FAITH AND HAPPINESS** LAS VEGAS. NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 072 Continued From page 2 Y 072 Y 072 449.196(3) Qualications of Caregiver-Med Y 072 SS=D re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 6/16/09, the facility failed to ensure that 1 of 3 caregivers had completed the required three hour medication management refresher training every three years (Employee #2). The most recent medication management training on file for Employee #2 was dated 2/19/05.

Severity: 2 Scope: 1

NAC 449.199

4493199(4) Staffing Schedule

Y 088

SS=C

Y 088

PRINTED: 06/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS4009AGC 06/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6418 SPRING MEADOW DRIVE **HOME OF FAITH AND HAPPINESS** LAS VEGAS, NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 088 Y 088 Continued From page 3 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. This Regulation is not met as evidenced by: Based on record review and interview on 6/16/09, the administrator failed to maintain a monthly staffing schedule that needs to be retained for at least six months. Severity: 1 Scope: 3 Y 100 Y 100 449.200(1)(a) Personnel File - Employee Info SS=E NAC 449.200 1. Except as otherwise provided in subsection 2. a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure a separate personnel file was

Scope: 2

449.200(1)(d) Personnel File - NAC 441A

kept for 2 of 3 employees.

Severity: 2

Y 103

SS=F

Y 103

PRINTED: 06/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS4009AGC 06/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6418 SPRING MEADOW DRIVE **HOME OF FAITH AND HAPPINESS** LAS VEGAS. NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 103 Continued From page 4 Y 103 NAC 449 200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Based on record review on 6/15/09, the facility failed to ensure 3 of 3 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #1,#2 & #3) for the protection of all residents. Severity: 2 Scope: 3 Y 105 449.200(1)(f) Personnel File - Background Check Y 105 SS=F NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 6/16/09, the facility failed to ensure 3 of 3 caregivers met background check requirements (Employee #1, #2 and #3).

Severity: 2 Scope: 3

		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED  06/16/2009			
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS CITY STA	ATE ZIP CODE	1 06/	16/2009		
HOME OF FAITH AND HAPPINESS			STREET ADDRESS, CITY, STATE, ZIP CODE  6418 SPRING MEADOW DRIVE  LAS VEGAS, NV 89103						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
Y 106	Continued From page	e 5		Y 106					
Y 106 SS=E	449.200(2)(a) Personnel File - 1st aid & CPR		₹	Y 106					
	information required p	st include, in addition to pursuant to subsection og that the caregiver is perform first aid and							
	This Regulation is not met as evidenced by: Based on interview and record review on 6/16/09 the facility failed to ensure the 2 of 3 employees had completed training in first aid and cardiopulmonary resuscitation.  Employee #1 had no documented evidence of completion of first aid and (CPR) cardiopulmonary resuscitation.		16/09,						
			of						
	Employee #2's currer certificate was expire								
	Severity: 2 Scope: 2								
Y 272 SS=C	449.2175(3) Service	of Food - Menus		Y 272					
		writing, planned a weel ed and kept on file for 9							
	This Regulation is not met as evidenced by:								

AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING B. WING						
NVS4009AGC						06/16/2009			
				RESS, CITY, STA					
				EPRING MEADOW DRIVE EGAS, NV 89103					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
Y 272	Continued From page	e 6		Y 272					
	Based on observation and interview on 6/16/09, the facility failed to ensure a planned, dated and posted menu was utilized.  Severity: 1 Scope: 3								
Y 273 SS=E	449.2175(4) Service	of Food - Special Diets		Y 273					
	NAC 449.2175 4. A resident who has been placed on a special diet by a physician or dietitian must be provided a meal that complies with the diet. The administrator of the facility shall ensure that records of any modification to the menu to accommodate for special diets prescribed by a physician or dietitian are kept on file for at least 90 days.		ded a y a						
	This Regulation is not met as evidenced by: Based on observation and interview on 6/16/09, the facility failed to provide a diabetic diet to 2 of 3 residents ordered a special diet (Resident #2 & #3).								
	Severity: 2 So	cope: 2							
Y 434 SS=F	449.229(3) Emergend	cy Drills		Y 434					
	monthly on an irregul record of each drill m	on must be performed ar schedule, and a writ ust be kept on file at th an 12 months after the	е						

		(X1) PROVIDER/SUPPLIER/C		A. BUILDING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	NVS4009AGC			B. WING		06/1	6/2009	
NAME OF PROVIDER OR SUPPLIER ST			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
HOME OF FAITH AND HAPPINESS				3 SPRING MEADOW DRIVE VEGAS, NV 89103				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
Y 434	Continued From page 7		Y 434					
	Based on record revie did not ensure that m conducted on an irreg	ot met as evidenced by: ew on 6/16/09, the facil onthly evacuation drills gular schedule for the p uary 1 2008 thru June	ity were ast					
	Severity: 2 Scope:	3						
Y 444 SS=F	Y 444 SS=F  NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility.  This Regulation is not met as evidenced by: Based on record review on 6/16/09, the facility did not ensure smoke detectors were tested 18 out of the past 18 months (January 2008 thru June 16, 2009).  There ws no documented evidence of smoke detector checks conducted at the facility.  This was a repeat deficiency from the 7/11/07 & 8/29/08 State Licensure survey.  Severity: 2 Scope: 3			Y 444				
			е					
			07 &					
Y 876 SS=C	449.2742(4) NRS 449	9.037		Y 876				
	NAC 449.2742 4. Except as otherwis subsection, a caregiv							

PRINTED: 06/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS4009AGC 06/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6418 SPRING MEADOW DRIVE **HOME OF FAITH AND HAPPINESS** LAS VEGAS. NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 876 Continued From page 8 Y 876 administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met. This Regulation is not met as evidenced by: Based on record review on 6/16/09, the facility failed to ensure that an ultimate user agreement was obtained for 3 of 3 residents. Severity: 1 Scope: 3 Y 896 449.2744(1)(b)(2) Medication / MAR Y 896 SS=C NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (2) The date and time that the medication was administered.

This Regulation is not met as evidenced by: Based on record review on 6/16/09, the facility failed to ensure a record of the medications administered to 3 of 3 residents were recorded on

the medication administration record.

Scope: 3

Severity: 1

AND DUAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/O		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
NVS4009AGC				B. WING		06/1	6/2009			
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	-				
HOME OF FAITH AND HAPPINESS				6418 SPRING MEADOW DRIVE LAS VEGAS, NV 89103						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
Y 923	Continued From page	9		Y 923						
Y 923 SS=F	449.2748(3)(b) Medic	cation Container		Y 923						
	NAC 449.2748 3. Medication, including over-the-counter med supplement, must be: (b) Kept in its original administered.	:	ny							
	This Regulation is not met as evidenced by: Based on observation on 6/16/09, the facility failed to keep medications belonging to 3 of 3 residents in their original container (Resident #1, #2 and #3).  6/16/09, interview with Employee #3 indicated		/ 3 t #1,							
	that the owner pre-pour 3 of 3 resident's medications into a weekly pill reminder, then Employee #3 administers the pre-pored medications to the residents.  Note: as of the survey dated 6/16/09, Employee #3 had not completed medication management training.  Severity: 2 Scope: 3		ı							
Y 936 SS=E		ent file		Y 936						
	NAC 449.2749  1. A separate file mus	st be maintained for each	ch							

PRINTED: 06/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS4009AGC 06/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6418 SPRING MEADOW DRIVE **HOME OF FAITH AND HAPPINESS** LAS VEGAS. NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 936 Continued From page 10 Y 936 resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 6/16/09, the facility failed to maintain a resident file for 2 of 3 residents (#1 & #2). Severity: 2 Scope: 2 Y1010 449.2764(1) MI Training Y1010 SS=D NAC 449.2764 1. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after he becomes employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 employees had not less than 8 hours of mental illness training within 60

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING \_ NVS4009AGC 06/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6418 SPRING MEADOW DRIVE HOME OF FAITH AND HAPPINESS** LAS VEGAS, NV 89103 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y1010 Continued From page 11 Y1010 days of employment at the facility (#3). Severity: 2 Scope: 1